Open Enrollment

Participating Groups

2010

Health • Prescription • Dental

State of Delaware

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Introduction & What's New!

2010 Benefits Open Enrollment

The State Employee Benefits Committee presents your 2010 Open Enrollment information. This comprehensive package covers the health, dental and prescription needs of all benefit eligible employees and their dependents. A few coverage changes are being implemented in an effort to control costs. These changes can be found in the What's New! section below. Please take the time to review all of the benefit options and choose the plans that fit your needs as open enrollment is the one time each year to enroll, make changes or terminate coverage in these plans. More information can be found at the Statewide Benefits website – ***www.ben.omb.delaware.gov****.*

Statewide Benefits Office Mission Statement

Our mission is to support the health of employees and pensioners by providing progressive comprehensive benefits, quality customer service, ongoing employee education and efficient management to ensure the best interests of program participants.

What's New!

Michelle's Law

- *This law allows a college student, enrolled as a dependent child on the employee's medical care plan, who suffers from a serious illness which requires the student to be on a medical leave of absence from school or a reduced class schedule (full-time to part-time) to retain medical care coverage via his/her parent's health care plan. A physician's documentation is required. Additional information is available at www.ben.omb.delaware.gov/medical.*

Mental Health Parity

- *This law allows members to receive equal coverage for mental health and substance abuse services, costs, and treatment as provided for medical or surgical benefits. Additional information is available at www.ben.omb.delaware.gov/medical.*

All Infertility Services

- *Members receiving infertility services included but not limited to In Vitro Fertilization (IVF) and Artificial Insemination, will be required to pay a 25% coinsurance for medical care and prescription services associated with these services. IVF services must be pre-approved by the medical care provider, Blue Cross Blue Shield of Delaware or Aetna. There will be a $10,000 lifetime maximum for medical care services for infertility and a $15,000 lifetime maximum for all medications for infertility. Members approved for IVF prior to July 1, 2010 and who have received IVF services through their medical carrier at any time since January 1, 2009, are responsible for the 25% coinsurance on all infertility services (medical care and prescription services) and will be "grandfathered" to retain a lifetime maximum of $30,000. Additional information is available at www.ben.omb.delaware.gov/medical.*

Bariatric Surgery

- *Members shall receive full medical care coverage for this type of surgery when the procedure is provided at an approved facility (hospital or surgical center). Members with medical care coverage through Aetna must utilize an "Institute of Excellence for Bariatric Surgery". Those members with medical care coverage through Blue Cross Blue Shield of Delaware must utilize a "Blue Distinction Center for Bariatric Surgery." If a member has a bariatric procedure performed at an unauthorized facility (hospital or surgical center) the member is responsible for 25% coinsurance. Additional information and listings of approved facilities are available at www.ben.omb.delaware.gov/medical.*

Virtual Colonoscopy

- *This method of colorectal screening is now available under all medical care plans. A Virtual Colonoscopy, also known as a Computed Tomographic Colonography (CTC), can replace the traditional Colonoscopy. Members are encouraged to discuss this procedure with their physician, as some members require a follow-up traditional Colonoscopy. The member is responsible for the applicable out-of-pocket expenses. Additional information is available at www.ben.omb.delaware.gov/medical.*

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If there is an conflict in interpretation between the contents of this booklet and the contract provisions and existing law pertaining to any of the enclosed benefit programs, contract provisions and existing law govern.

What's New!

High-Tech Imaging Scans and Tests

- *Scans and tests classified as High-Tech Imaging are Computerized Tomography (CT)/Computed Tomography Angiography (CTA), Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), and Nuclear Cardiac Imaging studies.*

  Requests for these tests, to be performed as an out-patient, must be reviewed and approved through MedSolutions to determine if the test is appropriate for the member's medical condition. It is the treating physician's responsibility to submit and receive approval for the high-tech imaging test(s) prior to the member receiving the test. When the physician receives approval the test may then be scheduled with the testing facility.

  Failure to receive approval prior to having the test performed will result in the claim being denied and the provider is held accountable for the entire cost of the test. Tests and scans performed during a member's hospitalization or Emergency Room visit are exempt from this program. The member is responsible for applicable out-of-pocket expenses. Additional information is available at www.ben.omb.delaware.gov/medical.

Hospice Care

- *All medical plans now include a 365 day hospice care benefit. Additional information is available at www.ben.omb.delaware.gov/medical.*

Prescription Plan Changes

- *Some health conditions require medications that are classified as "specialty medications" and are provided through Medco's Specialty Pharmacy, Accredo Health. Medications used to treat some forms of cancer and multiple sclerosis will be classified and administered as "specialty medications". Staff from Accredo Health will reach out to physicians and members to work together in managing the member's medical needs.*

- *Some medications used to treat migraine headaches are part of the Step Therapy Program, which requires the member to try one of the "preferred or formulary" medications, Sumatriptan, Maxalt, Maxalt MLT or Relpax, before obtaining a "non-preferred or non-formulary" medication. The non-preferred migraine headache medications are Amerge, Axert, Frova, Treximet and Xomig/ZMT.*

- *When a member receives a new prescription for Coumadin, or its generic Warfarin, (blood thinners) or a new prescription for Tamoxifen (used to prevent a recurrence of breast cancer), the member will be provided the opportunity to voluntarily participate in Medco's Personalized Medicine program. This program provides genetic testing to members using either of these medications to ensure that the medication is effective in treating the member's medical condition in accordance with the member's genetic characteristics.*

  Additional information is available at www.ben.omb.delaware.gov/script.

The benefits you elect during the Open Enrollment period will take effect July 1, 2010.

Please keep this booklet as a reference to use throughout the plan year.

*If you cover your spouse in one of the State of Delaware Group Health Insurance medical plans, you **MUST** complete a new Spousal Coordination of Benefits form each year during Open Enrollment and anytime your spouse's employment or insurance status changes.*
Failure to complete this form will result in a reduction of spousal benefits.

You may complete the form online at www.ben.omb.delaware.gov/documents/cob or you may complete the form on page 14 and submit it to your Human Resources or Benefits Office no later than May 19, 2010. ***Go to page 13 for complete details.***

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2010 Enrollment Action Checklist

OPEN ENROLLMENT is May 3 - May 19, 2010

- ❑ Read all Open Enrollment information contained in this booklet.
- ❑ Mark your calendar to attend one of the Statewide Benefit Health Fairs (see page 17 for dates, times, and locations).
- ❑ Review "Open Enrollment Frequently Asked Questions" (FAQ) located on the Statewide Benefits website at **www.ben.omb.delaware.gov/nonpayroll**.
- ❑ If you are not making any changes and **do not cover a spouse** under your State of Delaware Group Health Insurance medical plan, no action is required.
- ❑ **If you cover your spouse in one of the State of Delaware Group Health Insurance medical plans**, go to page 13 for complete details.
- ❑ Review State of Delaware HIPAA Privacy Notice at **www.ben.omb.delaware.gov/hipaa**.

If you are enrolling in any plan or enrolling a spouse or dependent for the first time…

- ❑ If enrolling in an HMO (health or dental) plan for the FIRST TIME, make sure, **before you enroll**, that your health or dental provider participates in the plan you select and enter their provider information online when you enroll. REMEMBER: You cannot change plans during the plan year if your provider decides to no longer participate in the plan.
- ❑ If enrolling a spouse for the FIRST TIME: You must supply a copy of your marriage certificate to your organization's Human Resources or Benefits Office.
- ❑ If enrolling a dependent for the FIRST TIME: You MUST submit a copy of the birth certificate or other legal document to your organization's Human Resources or Benefits Office.

About Your Health Care Coverage

Notice of Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. To request special enrollment or obtain more information, contact your organization's Human Resources or Benefits Office.

***Requests for special enrollment rights must be made within 30 days of the date of the qualifying event.**

Special Enrollment Rights for Individuals Eligible for the Delaware Healthy Children Program (CHIP)

If you or a dependent are eligible for but not enrolled in coverage under one of the State of Delaware Group Health Insurance plans, you may enroll in coverage if you or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility for that coverage, or you or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (not currently offered in Delaware). You must request enrollment in the plan within 60 days of the date you or your dependent lost Medicaid or CHIP coverage or within 60 days of the date your eligibility for premium assistance is determined under Medicaid or CHIP.

Qualifying Events

You may not make changes at any other time during the year unless you experience a qualifying event. Therefore, if you want to make any changes in your coverage, now is the time to do it.

Qualifying events include, but may not be limited to:

- Birth or adoption of a child
- Marriage
- Divorce
- Employment of spouse
- Involuntary loss of spouse coverage
- Spouse's employment termination
- Child now eligible for coverage
- Death of a spouse or dependent
- Spouse becomes a State of Delaware employee

If you want to make a benefit or dependent change as a result of a qualifying event during the year, you must contact your organization's Human Resources or Benefits Office within 30 days of the qualifying event and request the change.

You can find a complete copy of the State's Group Health Insurance Program Eligibility and Enrollment Rules at **www.ben.omb.delaware.gov/documents**.

About Your Health Care Coverage

Health Plan Descriptions

Aetna HMO

Simple, Smart and Save...Choose Aetna this Open Enrollment!

- **Local and National Network Access**-It's simple to access care from Aetna's large network of providers in DE, PA, SNJ, MD...and across the country!
- **Get Smart About Your Health**-Aetna's HMO includes your own Personal Health Record (PHR).
- **Save with Aetna Discount Programs**-Aetna offers discounts such as: Vision Discounts, Gym Discounts, Vitamin and Gym Equipment Discounts, Hearing Aid Discounts, Massage Therapy Services and more. Join Aetna and get these additional perks!

Referrals are required for certain services and are obtained through your primary care physician.

Call customer service at 1-877-542-3862 to learn more about how **Aetna HMO** has everything you need to help you be your healthiest. Additional information can be viewed at **www.ben.omb.delaware.gov/medical/Aetna**

Blue Cross Blue Shield of Delaware: First State Basic Plan

In-network services will have a deductible of $500 per individual and $1,000 per family. The plan will then pay at 90% of the BCBSD allowable charge. The out-of-pocket maximum is $2,000 per individual and $4,000 per family (including the deductible) per plan year. The out-of-pocket maximum applies to medical services only. Copayments for prescription medications are not applied to the out-of-pocket maximum. Preventive services are covered in network at 100% of the allowable charge and are not subject to a deductible or co-insurance. (See page 6).

Out-of-network services will be subject to a deductible of $1,000 per individual and $2,000 per family and then the plan will pay at 70% of the allowable charge. The out-of-pocket maximum is $4,000 per individual and $8,000 per family per plan year. (See page 6).

Blue Cross Blue Shield of Delaware: Comprehensive Preferred Provider Organization(PPO) Plan

Using in-network services you will pay a small copay/coinsurance with no deductible. If you use out-of-network providers, you must meet a $300 per person/$600 per family plan year deductible unless otherwise noted. The out-of-pocket maximum is $1,800 per person/$3,600 per family (including the deductible) per plan year. The out-of-pocket maximum applies to medical services only. Copayments for prescription medications are not applied to the out-of-pocket maximum.

Blue Cross Blue Shield of Delaware Blue Care® HMO

Blue Care® is BCBSD's HMO-Managed Care plan in which each member must select a primary care physician (PCP) to coordinate his/her health care needs. Referrals are required for certain services and are obtained through your primary care physician.

NOTE: BCBSD's allowable charges are based on the price BCBSD determines is reasonable for care or services provided.

***Complete information on all Blue Cross plans, including a summary plan description, can be found at www.ben.omb.delaware.gov/medical/bcbs**

Adult Dependent Program (ages 21 to 24)

The Adult Dependent Program is available to members of the State of Delaware's Group Health Insurance program to provide a period of health care coverage to adult dependents between the ages of 21 and 24 who are no longer eligible to be covered under the parent or legal guardian's State of Delaware plan due to age and non-student status.

An Adult Dependent must enroll in the same plan which provides coverage to their parent or legal guardian who has Group Health Insurance through the State of Delaware. Contact the appropriate health care carrier (Blue Cross Blue Shield of Delaware or Aetna) directly for more detailed information on eligibility, enrollment and payment requirements.

Enrollment is available during Open Enrollment or within 30 days of loss of coverage under the parent or legal guardian's State of Delaware plan.

Additional information can be viewed at www.ben.omb.delaware.gov/medical

***More information about changes to dependent coverage due to Health Care Reform will be available in the near future.**

Tip: Considering an HMO?

Go to the Statewide Benefits Office, OMB website at www.ben.omb.delaware.gov, under Group Medical Plans, select carrier (Blue Cross or Aetna). Select "Find a Health Care Provider" for BCBSD OR select "Locate Participating Providers - Doc Find" for Aetna to check on which health care professionals are on their approved provider lists.

Summary of Benefits

First State Basic Plan

This Summary of Benefits highlights the health plans available. Summary Plan Booklets are available at www.ben.omb.delaware.gov/medical.

Description of Benefit	In-Network Benefits Deductible: $500/$1,000* Out–of-Pocket Max: $2,000/$4,000** including deductible	Out-of-Network Benefits Deductible: $1,000/$2,000* Out-of-Pocket Max: $4,000/$8,000** including deductible
Inpatient Room & Board	90% after deductible	70% after deductible
Inpatient Physicians' and Surgeons' Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Prenatal and Postnatal Care	90% after deductible	70% after deductible
Delivery Fee	90% after deductible	70% after deductible
Hospice	90% after deductible for up to 365 days	70% after deductible for up to 365 days
Home Care Services	90% after deductible for up to 240 days per plan per year	70% after deductible for up to 240 days per plan per year
Urgent Care	100% after $25 copay	100% after $25 copay
Emergency Services	90% after deductible	70% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	90% after deductible (subject to authorization)	70% after deductible (subject to authorization)
Outpatient	90% after deductible	70% after deductible
OTHER SERVICES		
Durable Medical Equipment	90% after deductible	70% after deductible
Skilled Nursing Facility	90% for up to 120 days per confinement	70% for up to 120 days per confinement
Emergency Ambulance	90% after deductible	70% after deductible
Physician Home/Office Visits (sick)	90% after deductible	70% after deductible
Specialist Care	90% after deductible	70% after deductible
Chiropractic Care	90% after deductible for up to 30 visits per plan year	70% after deductiblefor up to 30 visits per plan year
Allergy Testing/Allergy Treatment	90% after deductible	70% after deductible
X-Ray, MRI's , CT Scans, PT Scans, Lab & Other Diagnostic Services	90% after deductible	70% after deductible
Short-Term Therapies: Physical, Speech, Occupational	90% after deductible(subject to authorization)	70% after deductible(subject to authorization)
Annual Gyn Exam/Pap Smear	100% covered, no deductible	70% covered, no deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100% covered, no deductible	70% covered, no deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% covered, no deductible	70% covered, no deductible
Hearing Aids	90% after deductible, under age 24	70% after deductible, under age 24
ALL INFERTILITY SERVICES		
	25% coinsurance $10,000 lifetime maxium for medical services 25% coinsurance $15,000 lifetime maxium for prescription services	25% coinsurance $10,000 lifetime maxium for medical services 25% coinsurance $15,000 lifetime maxium for prescription services
BARIATRIC SURGERY		
	Must use "Institute of Excellence for Bariatric Surgery" If an unauthorized hospital/surgical center, 25% coinsurance	Must use "Blue Distinction Center for Bariatric Surgery" If an unauthorized hospital/surgical center, 25% coinsurance

**Two individuals must meet the deductible each plan year in order for the family deductible to be met.*
*** Out-of-pocket maximums apply to each plan year and include your deductible but do not include your prescription costs.*

Summary of Benefits

Comprehensive Preferred Provider Organization

This Summary of Benefits highlights the health plans available. Summary Plan Booklets are available at www.ben.omb.delaware.gov/medical.

Description of Benefit	In-Network Benefits	Out-of-Network Benefits Deductible: $300/$600* Out-Of-Pocket Max: $1,800/$3,600 Including Deductible**
Inpatient Room & Board	$100 copay/day with max. of $200/admission	80% after deductible
Inpatient Physicians' and Surgeons' Services	100%	80% after deductible
Outpatient Services	100%	80% after deductible
Prenatal and Postnatal Care	100% (inpatient room and board copays do apply to hospital deliveries/birthing centers)	80% after deductible
Delivery Fee	100%	80% after deductible
Hospice	100% up to 365 days	80% after deductible up to 365 days
Home Care Services	100%	80% after deductible for up to 240 visits per plan year
Urgent Care	$25 copay	80% after deductible
Emergency Services	$125 copay (waived if admitted)/Physician: 100%	$125 copay (waived if admitted)/Physician: 80% after deductible
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	$100 copay/day with max of $200/adm. (subject to authorization)	80% after deductible (subject to authorization)
Outpatient	100% after $25 copay	80% after deductible
OTHER SERVICES		
Durable Medical Equipment	100%	80% after deductible
Skilled Nursing Facility	100% up to 120 days per confinement	80% after deductible up to 120 days per confinement
Emergency Ambulance	100%	100% no deductible
Physician Home/Office Visits (sick)	$15 copay	80% after deductible
Specialist Care	$25 copay	80% after deductible
Chiropractic Care	85% covered; 30 visits per plan year	80% after deductible; 30 visits per plan year
Allergy Testing/Allergy Treatment	Testing: $25 copay/ Treatment: $5 copay	80% after deductible
X-Ray, MRI's , CT Scans, PT Scans, Lab & Other Diagnostic Services	Lab: $5 copay per visit/X-ray: $15 copay per visit	80% after deductible
Short-Term Therapies: Physical, Speech, Occupational	85%	80% after deductible
Annual Gyn Exam/Pap Smear	Exam: $15 copay Pap Smear: $5 copay	80% after deductible
Periodic Physical Exams, Immunizations, Diabetes Education	100% after $15 copay	80% after deductible
Vision Care	Not covered	Not covered
Hearing Tests	100% after office visit copay	80% after deductible
Hearing Aids	100%, under age 24	80% after deductible, under age 24
ALL INFERTILITY SERVICES		
	25% coinsurance $10,000 lifetime maxium for medical services 25% coinsurance $15,000 lifetime maxium for prescription services	25% coinsurance $10,000 lifetime maxium for medical services 25% coinsurance $15,000 lifetime maxium for prescription services
BARIATRIC SURGERY		
	Must use "Institute of Excellence for Bariatric Surgery" If an unauthorized hospital/surgical center, 25% coinsurance	Must use "Blue Distinction Center for Bariatric Surgery" If an unauthorized hospital/surgical center, 25% coinsurance

**Two individuals must meet the deductible each plan year in order for the family deductible to be met.*
*** Out-of-pocket maximums apply to each plan year and include your deductible but do not include your prescription costs.*

Summary of Benefits

HMO Plans

This Summary of Benefits highlights the health plans available. Summary Plan Booklets are available at www.ben.omb.delaware.gov/medical.

Description of Benefit	Aetna	Blue Care
Inpatient Room & Board	$100 copay/day with max of $200/admission	$100 copay/day with max of $200/admission
Inpatient Physicians' and Surgeons' Services	100%	100%
Outpatient Surgery–Ambulatory Center	$30 copay	$30 copay
Outpatient Surgery–Doctor's Office Visit	$20 copay	$20 copay
Outpatient Surgery–Hospital	$75 copay	$75 copay
Prenatal and Postnatal Care	100% after $20 initial copay (inpatient room and board copays do apply to hospital deliveries/birthing centers)	100% after $20 initial copay (inpatient room and board copays do apply to hospital deliveries/birthing centers)
Delivery Fee	100%	100%
Hospice	100% up to 365 days	100% up to 365 days
Home Care Services	100% for up to 240 visits per plan year	100% for up to 240 visits per plan year
Urgent Care	$20 copay	$20 copay
Emergency Services	$135 copay (waived if admitted)	$135 copay (waived if admitted)
MENTAL HEALTH CARE/SUBSTANCE ABUSE CARE		
Inpatient Acute/Partial Hospitalization	$100 copay/day with max. of $200/hospitalization (subject to authorization)	$100 copay/day with max. of $200/hospitalization (subject to authorization)
Outpatient	$20 copay per visit	$20 copay per visit
OTHER SERVICES		
Durable Medical Equipment	80%, limited to $5,000 per member per plan year	80%
Skilled Nursing Facility	100%	100%
Emergency Ambulance	$50 copay	$50 copay
Physician Home/Office Visits (sick)	$10 copay per office visit $25 copay per home or after hours visit	$10 copay per office visit $25 copay per home or after hours visit
Specialist Care	$20 copay per visit	$20 copay per visit
Chiropractic Care	$20 copay per visit	$20 copay first visit, then 80%/up to 60 consecutive days per condition
Allergy Testing/Allergy Treatment	$20 copay per visit (allergy testing)/ $5 copay per visit (allergy treatment)	$20 copay per visit (allergy testing)/ $5 copay per visit (allergy treatment)
X-Ray, Lab & Other Diagnostic Services	Lab: $5 copay per visit/X-Ray: $15 copay per visit	Lab: $5 copay per visit/X-Ray: $15 copay per visit
MRI's , CT Scans, & PET Scans	$25 copay per visit	$25 copay per visit
Short-Term Therapies: Physical, Speech, Occupational	80%, 45 visits per condition for physical and occupational therapy combined/ 80%, 45 visits per condition for speech therapy	80%, 60 consecutive days/except for physical therapy. Physical therapy/45 visits per condition
Annual Gyn Exam Pap Smear	Exam: $10 copay Pap Smear: $5 copay	Exam: $10 copay Pap Smear: $5 copay
Periodic Physical Exams, Immunizations, Diabetes Education	$10 copay per visit/100% Diabetes education	$10 copay per visit/100% Diabetes education
Vision Care	100% after office visit copay (one exam every 24 months)	100% after office visit copay (one exam every 24 months)
Hearing Tests	100% after office visit copay	100% after office visit copay
ALL INFERTILITY SERVICES		
	25% coinsurance $10,000 lifetime maxium for medical services 25% coinsurance $15,000 lifetime maxium for prescription services	25% coinsurance $10,000 lifetime maxium for medical services 25% coinsurance $15,000 lifetime maxium for prescription services
BARIATRIC SURGERY		
	Must use "Institute of Excellence for Bariatric Surgery" If an unauthorized hospital/surgical center, 25% coinsurance	Must use "Blue Distinction Center for Bariatric Surgery" If an unauthorized hospital/surgical center, 25% coinsurance

Prescription Coverage

Medco

When you enroll in a health care plan, you will automatically be enrolled in the prescription drug plan managed by Medco Health Solutions, Inc. (Medco). The Coordination of Benefits (COB) policy also applies to prescription coverage. If your spouse or dependents have other health coverage that is primary (pays first), the prescription coverage provided through the State's plan for the spouse or dependents will become secondary.

The State of Delaware, in partnership with Medco, has designed and implemented a comprehensive prescription drug program to provide you with the medications required in a cost-effective and efficient manner. Your copays remain unchanged for the coming plan year.

Copay for diabetic supplies is $0. If multiple prescriptions are filled for diabetic medications on the same date, only one copay is charged regardless of the number of diabetic medications filled. Contact Medco at 1-800-939-2142 for details on covered supplies.

2010 Prescription Copay Rates

STATE OF DELAWARE PRESCRIPTION COVERAGE	TIER 1 GENERIC	TIER 2 PREFERRED	TIER 3 NON-PREFERRED
30-DAY SUPPLY	$8.50	$20.00	$45.00
90-DAY SUPPLY	$17.00	$40.00	$90.00

No Changes to Copays in 2010

Maintenance Medication Program

Maintenance Medications are those used to treat chronic conditions and long-term conditions. Examples include blood pressure medications, cholesterol-lowering medications, and asthma medications. For more information, see **www.ben.omb.delaware.gov/script**.

Since July 1, 2009, the State of Delaware Prescription Plan has required that maintenance medications be filled for 90 days and a penalty applies when a 30-day prescription is filled for the 4th time. The penalty is that the member receives a 30-day supply of medication and is charged the 90-day copay, as shown on the chart below.

STATE OF DELAWARE MAINTENANCE MEDICATION PROGRAM	TIER 1 GENERIC	TIER 2 PREFERRED	TIER 3 NON-PREFERRED
Penalty: On the 4th fill of a 30-day supply of a Maintenance Medication member receives 30 days of medication and pays the 90-day copay	$17.00	$40.00	$90.00

Members can avoid paying a penalty by asking their doctor to write maintenance medication(s) prescriptions for a 90-day supply. Members can then fill 90-day prescriptions:

1. At **retail pharmacies participating in the 90-day network**: Visit the Statewide Benefits website at **www.ben.omb.delaware.gov/script** to view a list of retail pharmacies participating in the 90-day network or call Medco at **1-800-939-2142** to ask about a particular pharmacy.

2. Through **Medco By Mail**: To get started call **1-800-939-2142** to speak with one of Medco's Member Services representatives.

CHANGES TO PRESCRIPTION PLAN AS OF JULY 1, 2010

Specialty Medications – Some health conditions require medications that are classified as "specialty medications" and are provided through Medco's Specialty Pharmacy, Accredo Health. Medications used to treat some forms of cancer and multiple sclerosis are classified and administered as "specialty medications." For additional information, see **www.ben.omb.delaware.gov/script**.

All Infertility Program Medications – Prescriptions for all infertility medications have a 25% coinsurance. For more information on All Infertility Program Medications, including coinsurance and lifetime maximums, visit **www.ben.omb.delaware.gov/medical**.

Prescription Coverage

Migraine Medications – Some medications used to treat migraine headaches (Amerge, Axert, Frova, Treximet and Xomig/ZMT) are now part of the Step Therapy Program, which requires members to try one of the "preferred or formulary" medications (Sumatriptan, Maxalt, Maxalt MLT or Relpax) before obtaining a "non-preferred or non-formulary" medication. For more information, see **www.ben.omb.delaware.gov/script**.

Coumadin/Warfarin and Tamoxifen – When a member receives a new prescription for Coumadin, or its generic Warfarin (blood thinners), or a new prescription for Tamoxifen (used to prevent recurrence of breast cancer), the member will be provided the opportunity to voluntarily participate in Medco's Personalized Medicine program. This program provides genetic testing to members using either of these medications to ensure that the medication is effective in treating the member's medical condition in accordance with the member's genetic characteristics. For more information, see **www.ben.omb.delaware.gov/script**.

The Coverage Review Process

The Coverage Review Process was designed to ensure that plan participants receive prescription medication that results in appropriate, cost-effective care. If you are taking any of the medications referenced in the programs below, Medco will review the prescriptions with your doctor before the prescription is filled if additional information is required. The Coverage Review Process uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and usage that is considered reasonable, safe and effective. You, your doctor or your pharmacy may begin the Coverage Review Process by calling 1-800-753-2851 from 8:00 a.m. to 9:00 p.m., Monday through Friday. The Coverage Review Process usually takes two business days to complete upon receipt of necessary information. You and your doctor will receive written confirmation of approval or denial. The following programs fall under the Coverage Review Process:

Traditional Prior Authorization requires that you obtain pre-approval through a coverage review for certain medications. The review will determine whether your plan covers your prescribed medication. Examples of common medications that may require prior authorization are: Botox and Myobloc, Regranex, Synagis and Respigam, Xolair, medications that may have cosmetic uses, Erythroid Stimulants used for certain anemias, Growth Hormones used to stimulate skeletal growth and Psoriasis medications.

Step Therapy is an automated process used to determine whether you qualify for coverage using factors Medco has on file, such as medical history, drug history, age and gender. If your history does not qualify you for coverage, a prior authorization is required to permit coverage. Certain medications may not be covered unless you have first tried another medication or therapy. These medications are part of this process: Forteo, Revatio, COX-II Inhibitors such as Celebrex, injectable rheumatoid arthritis medications, select high blood pressure (ARB's) medications such as Benicar, Proton Pump Inhibitors such as Aciphex or Prevacid and select antidepressants such as Lexapro, and Migraine Headache medications such as Imitrex and Maxalt.

Quantity Duration Rules are in place for some medications which require a Coverage Review Process to request additional quantities. These include medications used to help you sleep such as Ambien and Lunesta, selected antifungal medications such as Sporanox and Lamisil, selected migraine medications such as Imitrex and Maxalt, selected nausea medication such as Anzemet and Zofran and erectile dysfunction medications such as Cialis and Viagra.

The Choice Program…Generic vs. Brand Drugs allows you to receive a brand name medication when a generic drug is available; however, you will be responsible for the generic copay plus the cost difference between the generic and the brand drug. If there is a medical reason why you cannot take the generic equivalent, you, your doctor or your pharmacist may initiate the copay appeal process to allow you to obtain the brand drug at the non-preferred copay.

Certain medications are not covered by the prescription drug plan including drugs for weight loss, allergy shots, reusable syringes, immunizations and injectable medication administered in the doctor's office.

NOTE: *All drugs and categories listed above are subject to change.*

Questions About Your Prescription Coverage

If you have specific questions about medication or pharmacy participation, contact Medco's Member Services at 1-800-939-2142, 24 hours a day, 7 days a week. Pharmacists are available around the clock for medication consultations. Medco's website, **www.medco.com** offers extensive online resources, including health and benefit information and online pharmacy services.

Employee Assistance Program (EAP)

Balancing the needs of work, family and personal responsibilities can be challenging. To make the balancing act a little easier, Human Management Services, Inc. (HMS) offers a place to turn for confidential assistance. The EAP offers face-to-face assessment and confidential counseling services to employees, pensioners and their dependents enrolled in a non-Medicare health insurance plan and offers confidential assistance in the following areas:

- Marital Relationships
- Family Issues
- Alcohol and Drug Abuse
- Child Care
- Parenting Issues
- Elder Care
- Productivity Problems
- Adolescent Issues
- Balancing Work and Family
- Financial Issues
- Stress Management
- Legal Issues
- Difficult Emotional Problems
- Grief and Loss

To receive an assessment and/or up to five short-term counseling sessions free of charge, call HMS at 1-800-343-2186 or visit HMS online at **www.hmsincorp.com** to access EAP or Work/Life services. If your HMS professional refers you to another provider for continued assistance you will incur out-of-pocket expenses. Additional information may be viewed at **www.ben.omb.delaware.gov/eap**

- **Log in to the HMS website using the following:**

  Username: **Delaware**
  Password: **statehms04**

About Your Dental Plan

Delta Dental and Dominion Dental Services administer the State's dental programs for 2010.

Remember:

Enrollment in any of these dental plans is a Binding Election until next year's open enrollment. If you are enrolling in the Dominion Dental HMO–before you enroll make sure your dentist participates in the plan you select. You cannot change plans or drop coverage during the plan year if your dentist decides to no longer participate in the plan. You will be given the opportunity to choose another participating dentist. Call before enrolling to be sure the dentist is accepting new patients.

Delta Dental PPO Plus Premier Plan

This program allows you to visit any dentist you choose and receive applicable benefits. You'll save the most if you visit a dentist who participates with Delta Dental. You do not have to pick a primary care dentist; you are free to choose any dentist for any covered service at any time.

Your Delta Dental program gives you access to two Delta Dental dentist networks at once that offer different degrees of savings. You can choose a dentist from the larger Delta Dental Premier® network or one from the smaller Delta Dental PPO network,which features lower allowances and lower out of-pocket costs or a dentist who does not participate with Delta Dental. Your choice of dentists can determine the cost savings you receive.

Delta Dental payments vary by service, based on Delta Dental's schedule of allowed amounts for its networks. Reimbursement maximums and deductibles apply. Your annual reimbursement maximum is $1,500 per plan year per participant. Delta Dental dentists cannot balance bill above the allowed amount for covered services. Additional information can be viewed at **www.ben.omb.delaware.gov/dental/delta** including a dentist directory or by contacting Customer Service at 1-800-873-4165.

Dominion Dental HMO Plan (same as a DHMO)[1]

Dental Plan 605xs

Dominion Dental's Select Plan emphasizes prevention and early detection of dental problems. Carefully selected, established members of the dental community are contracted to deliver quality dental services. Choose any general dentist from the list of participating dentists to receive care.

Benefits include no charge for oral examinations, routine semi-annual cleanings, bitewing X-rays and topical fluoride for children (after the $10 office visit copay). These procedures account for over 65% of dental services most frequently performed for adults and almost 90% of the most frequently performed services for children.[2] More extensive care (fillings, crowns, dentures, root canals, periodontal care, oral surgery, orthodontics, etc.) is covered at fees up to 70% lower than usual and customary charges.[3] Specialty care is provided at the listed copayment, whether performed by a participating general dentist or a participating specialist. Referrals to a specialist must be made by the member's participating general dentist.

Features Include: No deductibles, no waiting periods, no pre-treatment estimates, no maximum annual dollar limits, no pre-existing condition exclusions and no claim forms.

Additional information can be viewed at **www.ben.omb.delaware.gov/dental/dom** or by calling 1-888-518-5338.

[1]Same as DHMO with fixed member co-payments, no annual maximum dollar limits, no waiting periods, no deductibles, no pre-authorization paperwork or pre-treatment estimates and no claim forms or proof of loss (except in the case of out-of-area emergencies).
[2]Dominion Dental Services, Inc. – based on annual review of utilization data.
[3]Based on the Captiva context fee schedule's 80th percentile fee information.

	Total Monthly Rate	Participating Group Pays	Employee Pays
Dominion Dental HMO *Administered by Dominion Dental*			
Employee	$21.28	$0.00	$21.28
Employee & Spouse	$35.64	$0.00	$35.64
Employee & Child(ren)	$43.16	$0.00	$43.16
Family	$50.68	$0.00	$50.68
Delta Dental PPO Plus Premier *Administered by Delta Dental*			
Employee	$25.10	$0.00	$25.10
Employee & Spouse	$51.22	$0.00	$51.22
Employee & Child(ren)	$50.28	$0.00	$50.28
Family	$83.90	$0.00	$83.90

State of Delaware – Spousal Coordination of Benefits Policy – Participating Groups

The State of Delaware Spousal Coordination of Benefits Policy was instituted on January 1, 1993. The policy states that **if:**

- the covered employee's spouse is employed by another employer, **and**
- that employer offers group health coverage, **and**
- the employer pays at least 50% of the premium for the lowest employee only plan, **then**, the spouse must obtain coverage as primary through his/her employer.

When the spouse of the State employee is covered through an employer who participates in the State of Delaware Group Health Insurance Program, the spouse MUST elect coverage through his/her employer as primary.

Therefore, if you are a Participating Group employee, married to a State of Delaware employee who is enrolled in the State's Group Health Insurance Program, you MUST elect coverage for yourself through your organization.

The State employee can maintain his/her policy through the State and include any dependent children on his/her policy, or elect to drop his/her State coverage and be covered under the Participating Group employee's policy. **Please note:** All participants and dependents MAY NOT be covered by more than one health plan through the State's Group Health Insurance Program.

- If the spouse is a State employee who elects to be covered under the Participating Group's policy rather than their State organization, you must complete a Spousal Coordination of Benefits Form and enter State of Delaware as the spouse's employer on the form. **Failure to complete this form will result in a reduction of spousal benefits.**

  You may complete the form online at www.ben.omb.delaware.gov/nonpayroll or you may complete the form on page 14 and submit to your organization's Human Resources or Benefits Office no later than May 19, 2010.

- A Participating Group employee whose spouse works for employers other than the State of Delaware is required to complete a Spousal Coordination of Benefits Form during the open enrollment period, as well as anytime there is a change in the spouse's employment status. The spouse will be required, in accordance with the Spousal Policy, to obtain coverage through their employer as primary, but may be on the State employee's contract for secondary coverage.

- When completing the form online, click on "Printable Summary" to print a copy of your submission for your records.

- If your spouse's employer offers a High Deductible health Plan with a Health Savings Account (HSA), you and your spouse should take careful note of important information regarding these plans on our website at **www.ben.omb.delaware.gov/nonpayroll**.

If completing the paper form on page 14, the completed form must be returned to your organization's Human Resources or Benefits Office no later than May 19, 2010. **Failure to complete this form will result in a reduction of spousal benefits.**

Spousal Coordination of Benefits Policy Form

State of Delaware

PLEASE PRINT ALL INFORMATION REQUESTED

Check Carrier: ☐ Blue Cross ☐ Aetna

YOUR FULL NAME - Last, First, Middle Initial		YOUR HOME PHONE - Include area code	
YOUR SOCIAL SECURITY NUMBER		Are you and your spouse both benefit eligible State of Delaware employees or retirees? ☐ Yes ☐ No	
SPOUSE'S FULL NAME - Last, First, Middle Initial	SPOUSE'S SOCIAL SECURITY NUMBER	☐ Male ☐ Female	SPOUSE'S BIRTH DATE / /

SPOUSE INFORMATION

My spouse is: ☐ Not Employed ☐ Employed Full-time ☐ Employed Part-time ☐ Self-employed ☐ Retired

NAME AND ADDRESS OF SPOUSE'S EMPLOYER (If spouse is a benefit eligible State of Delaware employee, simply write State of Delaware in this box and sign/date form)		SPOUSE'S EMPLOYER PHONE NUMBER Include Area Code
Does your spouse's employer offer medical insurance to employees? ☐ Yes ☐ No	Is your spouse enrolled in medical insurance through his or her employer? ☐ Yes ☐ No Is this a High Deductible Plan with a Health Savings Account (HSA)? ☐ Yes ☐ No	If not enrolled, what percentage of the premium of the lowest benefit employee only plan would your spouse be required to pay?* **Flexible benefits and credits apply toward employer's contribution*
What is the name of your spouse's medical insurance carrier'?	What is your spouse's plan policy number? Effective Date:	Annual plan renewal date for your spouse's employer: Month: Day:
Does your spouse's medical plan cover prescription drugs? ☐ Yes ☐ No	Your additional comments:	
If you are completing this form due to your spouse's loss of coverage please indicate the termination date of that coverage.	Date:	

AUTHORIZATION

I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers:

- This information will be shared with the State of Delaware's plan administrator(s).
- If spouses take advantage of their own employer's medical coverage, their plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's family benefit plan, not exceeding a limit of 100% coverage from both plans combined.
- If spouses do not take advantage of their own employer's medical coverage, the State will pay 20% of covered services provided by the employee's State of Delaware benefit plan.

I understand this form must be completed in order to cover my spouse on my State of Delaware Group Health Insurance plan. The form is used to determine a spouse's eligibility to receive primary State of Delaware health benefits. Generally, the following spouses are eligible for primary coverage:

- Spouses not working full time, or
- Spouses whose employer does not offer medical coverage, or
- Spouses whose employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available.

If any of this information changes, I must complete a new form within 30 days.

Notice to all parties completing this form: To insure benefits are coordinated properly between employers, the State of Delaware will verify the accuracy of information by conducting audits, contacting you, and contacting your spouse's employer. It is fraudulent to fill out this form with any information which is false or to omit important facts. Providing false information may result in disciplinary action.
Please return completed form to your organization's Human Resources or Benefits Representative.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT

Employee's Signature Date: / /

A complete copy of the State of Delaware's Spousal Coordination of Benefits Policy can be found online at **www.ben.omb.delaware.gov/documents/cob**

Benefits Health Fairs

Mark Your Calendar to Attend a Health Fair!

If you have questions about the 2010 Open Enrollment or your benefits, please attend a benefit health fair scheduled at various site locations in each county. Health Fair dates and location information are listed below:

Date	Time	Location	Address
New Castle County			
Monday, May 3, 2010	10 a.m. - 2 p.m.	Carvel State Building ***2nd Floor Mezzanine*** ***(Elevator is accessible)***	820 N. French Street Wilmington, DE 19801 ***Directions:*** http://omb.delaware.gov/admin/locations.shtml
Friday, May 14, 2010	2 p.m. - 6 p.m.	Cranston Heights Fire Company ***Fire Hall***	3306 Kirkwood Highway Wilmington, DE 19808 ***Directions:*** www.mapquest.com
Kent County			
Wednesday, May 5, 2010	10 a.m. - 2 p.m.	Delaware Technical and Community College, Terry Campus ***Education & Technology Building – Room 727***	100 Campus Drive • Dover, DE 19901 ***Directions:*** www.dtcc.edu/terry
Monday, May 10, 2010	2 p.m. - 6 p.m.	The Duncan Center ***The Outlook Conference Room*** ***5th Floor*** ***(Elevator is accessible)***	500 W. Loockerman Street Dover, DE 19904 ***Directions:*** www.theduncancenter.com
Sussex County			
Friday, May 7, 2010	10 a.m. - 2 p.m.	DHSS Stockley Center ***All-Star Building***	26351 Patriots Way Georgetown, DE 19947 ***Directions:*** www.dhss.delaware.gov (click on office locations listed under menu)
Wednesday, May 12, 2010	2 p.m. - 6 p.m.	Bridgeville Vol. Fire Company Station 72 ***Fire Hall – 2nd Floor*** ***(Elevator is accessible)***	313-315 Market Street Bridgeville, DE 19933 ***Directions:*** www.mapquest.com

Phone Numbers and Websites

Company Name	Phone Number	Website
Aetna	1-877-542-3862	***www.aetna.com***
Blue Cross Blue Shield of Delaware	302-429-0260 or 1-800-633-2563	***www.bcbsde.com***
Human Management Services, Inc. (HMS) **(Employee Assistance and Work/Life Program)**	1-800-343-2186	***www.hmsincorp.com*** USERNAME: Delaware PASSWORD: statehms04
Medco	1-800-939-2142	***www.medco.com***
Delta Dental	1-800-873-4165	***www.deltadentalins.com/*** ***stateofdelaware***
Dominion Dental Services	1-888-518-5338	***www.dominiondental.com***
Ceridian, COBRA Administration	1-800-877-7994	***www.ceridian-benefits.com***
Elder Information Hotline	1-800-336-9500	
Statewide Benefits Office, **Office of Management and Budget**	302-739-8331 or 1-800-489-8933	***www.ben.omb.delaware.gov***